DRAFT

Supervisory Agreement

As required by statute, a licensed physician assistant must have a practice agreement with a licensed physician approved by the Medical Licensing Board of Indiana after review by the Physician Assistant Committee prior to beginning practice.

| Physician Assistant | |
|--|----|
| PA License Number | |
| Address: | |
| Phone: | |
| Supervising Physician | |
| Physician License Number | |
| Address: | _ |
| Phone: | |
| Supervising Physician | |
| Physician License Number | |
| Address: | |
| Phone: | |
| (add additional pages if necessary) | |
| The physician assistant is delegated to perform the following tasks and procedures the are within the physician assistant's education and training and the supervising physic scope of practice: | |
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| The physician assistant will be providing the services described above in the followir settings: | ıg |

| The physician assistant will follow the procedure described below for dealing with emergencies: | | | | |
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| A physician assistant may prescribe medications included in the supervising physician's scope of practice as delegated by the supervising physician. The classifications of drugs delegated may not include Schedule I, and II medications or Schedule III-V medications containing oxycodone. Please list the classifications of medications the PA is delegated to prescribe: | | | | |
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| A supervising physician must describe the protocols to be used for the PA's prescribing. This may include clinical practice guidelines, referenced texts or other sources. Describe the protocols to be used in your practice: | | | | |
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A PA may be delegated ability to prescribe if the PA has completed 30 contact hours of instruction in pharmacology. Please attach verification of 30 hours of pharmacology from an accredited PA program or Category I CME activity.

A PA may be delegated ability to prescribe if the PA has one year of work experience as a practicing physician assistant. (This is defined as a minimum of 1800 hours of practice.) Attach documentation of this experience.

| Sign and date this form. | | |
|--------------------------|------|----------|
| | PA | MD or DO |
| | date | date |
| | | MD or DO |
| | | date |
| | | MD or DO |
| | | date |
| | | |

Attach additional pages for additional supervising physicians if needed.